



THE LOWER EXTREMITY FUNCTIONAL SCALE

Patient Name: _____ Date: _____

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, re creational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
	Column Totals:					

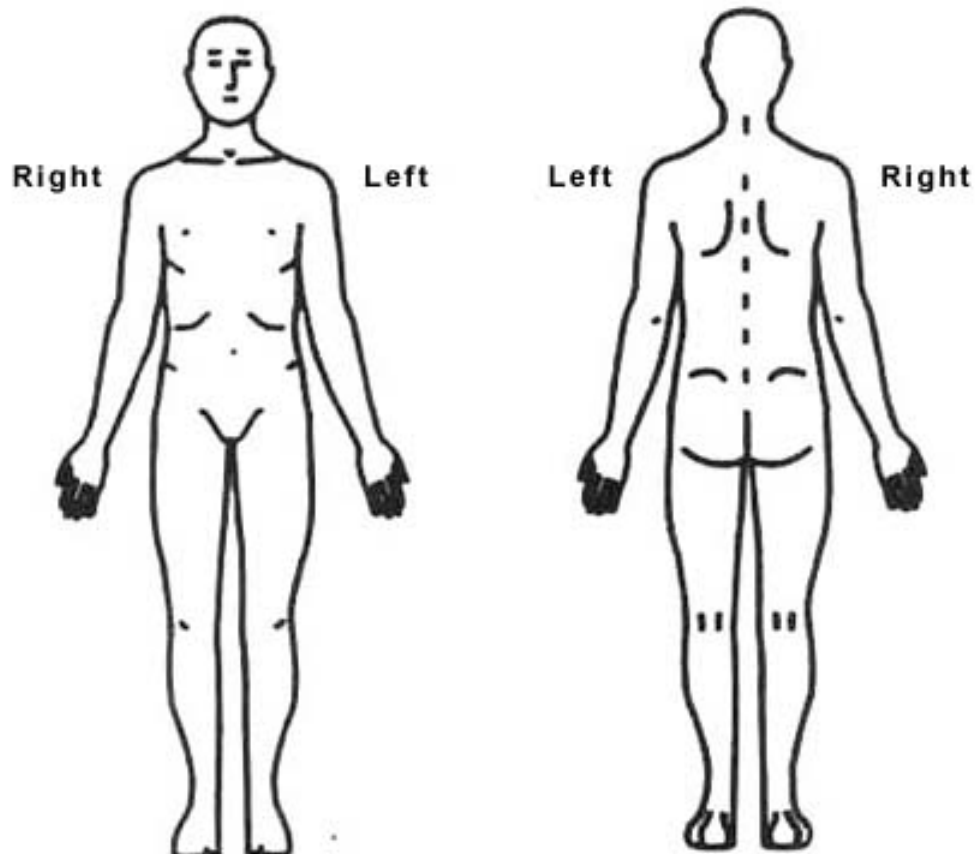
SCORE: ____ / 80



Pain Levels

- 10 Pain so intense you will go unconscious shortly.
- 9 Pain so intense you cannot tolerate it and demand pain killers or surgery.
- 8 Pain so intense you can no longer think clearly at all.
- 7 Intense pain causing you to think unclearly about half the time.
- 6 Piercing pain that causes you to think somewhat unclearly.
- 5 Strong deep pain that makes you pre-occupied with trying to manage it. Your normal lifestyle is curtailed.
- 4 Strong pain like an average toothache.
- 3 Very noticeable pain, like an accidental cut or blow to the nose.
- 2 Minor pain like lightly pinching the fold of skin between the fingers.
- 1 Very light barely noticeable pain.
- 0 No pain.

Please **mark** area of pain with an X and **label** with numbers.





Prior Therapy Form

Patient Name: _____

Date: _____

Are you currently a resident of a skilled nursing home? Yes No

Are you currently receiving home health care? Yes No

Please indicate if you have had any prior physical therapy or chiropractic care:

(Please include both inpatient and outpatient therapy)

Dates	Locations

Patient Signature: _____